INSTRUCTIONS FOR DATE OF SERVICE / UNIFORM BILLING DOCUMENT
(Long Form - must be submitted on legal size paper)

1. **PROVIDER:** Provider name as contracted with DES/DDD.

2. **FEDERAL EMPLOYER IDENTIFICATION/SOCIAL SECURITY NUMBER:** Provider's Federal Employer Identification
   Social Security Number.

3. **ADDRESS:** Provider address.

4. **GROUP AHCCCS ID:** The Provider's group AHCCCS ID number.

5. **INDIVIDUAL PROVIDER AHCCCS ID:** For Group Billers, enter the direct service provider's AHCCCS ID.

6. **CONTRACT NUMBER:** The Provider's contract number. This contract # must correspond to the fiscal year that bills are submitted.

7. **SERVICE:** The service that is being billed.

8. **MONTH/YEAR OF SERVICE:** The month and the year that is being billed.

9. **BUDGET SOURCE:** Please leave this area blank.

10. **PROVIDER LOCATION:** Two letter providers **Location Site Code** where service was delivered. (e.g. AA, AB, etc.)

11. **CONSUMER NAME**

12. **CONSUMER ASSIST ID**: This is the ASSISTS consumer identification number assigned by the ADES/DDD.

13. **INDIVIDUAL DATES OF SERVICE:** Do not fill in with an X. Enter the **number** of units delivered for each specific date of service. If daily unit, enter 1 for each service delivery date; if hourly unit, enter number of service hours delivered each day.

14. **POS:** The Place of Service code. The two-digit code indicates the **type of setting** where the service was delivered.

PLACE OF SERVICE:

TWO DIGIT CODE	TYPE OF SETTING
11	OFFICE
12	PATIENT'S RESIDENCE (home, ADH, CDH, Group Home IDLA, Etc.)
22	OUTPATIENT HOSPITAL
31	SKILLED NURSING FACILITY
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
56	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
99	OTHER UNLISTED FACILITY (E.G., PARK, STORE, TRANSPORTATION, ETC.)

15. DELIVERED UNITS: Enter the number of units delivered.

16. NO SHOW/ABSENT Units: Enter the number of absent units (RSA services only) or no show units (therapy treatments only). (Absent or No Show units billed for services other than RSA or therapy treatments will be cause to reject bill.). Indicate billable no show as NS; and billable absent as A, otherwise leave blank.

17. TOTAL UNITS: Sum of Column 15 and Column 16.

18. SERVICE CODE: The 3-digit service code that corresponds to the service being billed under #7 above.

19. TPL CODE: For TPL Billing ONLY: Third Party Liability Code. NOTE: For all consumers having insurance, please include an Explanation of Benefits (EOB) that corresponds to the service and date delivered or a waiver.

20. TPL AMOUNT: For TPL Billing ONLY: Third Party Liability amount paid by insurance company. This amount is deducted from the amount to be paid by the Division.

21. RATE. Published Rate for service delivery or contracted rate for non-557 services.

22. TOTAL: Enter the total dollars for line. Units **times** Rate (less TPL amount if applicable)

23. PAGE TOTAL. Total all of column 22.

***PREPARER'S and PROVIDER'S SIGNATURES:** The signature of the individual preparing this invoice.

***DATE:** The date on which the preparer signed the invoice.

NOTE: Uniform Billing Documents will only be accepted after the last date of service for the month billed. It must be submitted on 8.5 X 14 legal size paper

DO NOT SHRINK DOWN TO 8.5 X 11 SIZE PAPER